Exhibit 8

Employee File Inquiry

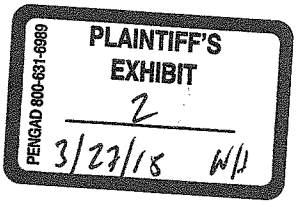
Employee Name Data
POWELL, QUANANE

Employee Address Data
[redacted]

[redacted]
Beneficiary

Shop: 0502 Soc Sec #: [redacted]
Dues Class: DUES Rate: $30.00
Med Plan: Rate: $.00
Med Coverage Start Date:
Sex: M Marital Status:
Phone Number: (000) 000-0000
Date Of Birth: [redacted]
Date Of Death:
Date Of Init: 6/01/2015
Date Of Re-hire:
Date Of Term: 10/01/2015

F3 End F6 Dues Inquiry F8 Hiring Hist



LBP → 6/15
LG

JUN 19 2015

LIFE

League of International Federated Employees
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single as per Francesco

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages initiation fees and dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1978. The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation signed by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

"Contributions of gifts to L.I.F.E. are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses."

Signature Quamaine Powell Date 6-19-2015

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

(PLEASE PRINT OR TYPE) #0506 #0502

Your Last Name	First Name	Middle Name	Sex	Date of Birth Mo. Day Year
Powell	Quamaine	Jr.	☑ M ☐ F	[redacted]

Address / City / State / Zip Code: [redacted]

Home Telephone #: [redacted]

Name of Employer	Date Employed
Liberty Ashes Inc.	

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe)	Relationship

Are you covered by any other Health Insurance? ☐ Yes No ☑ Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☑ No ☐

List below all family members to be covered. Name (indicate ... name if applicable)	Birth Date MO DAY YR	Relationship
SS#	/ /	☐ Husband ☐ Wife
SPOUSE'S NAME LAST (If Different) FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT [redacted]	[redacted]	☑ Son ☐ Daughter
DEPENDENT LAST (If Different) FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT LAST (If Different) FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT LAST (If Different) FIRST	/ /	☐ Son ☐ Daughter

ENTERED

JUN 19 2015

I hereby apply for that coverage for which I am or may become eligible under the group policy or policies issued by L.I.F.E. Benefit Plan. I authorize such deductions, if any, from my earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under any life insurance issued and certify that the above is my correct date of birth. I have read this or it has been explained to me and I am signing on the reverse side.

Employee File Inquiry

Employee Name Data
MENNA, LEONARD J.

Employee Address Data
[redacted]

[redacted]
Beneficiary

Shop: 0502 Soc Sec #: [redacted]
Dues Class: DUES Rate: $30.00
Med Plan: Rate: $.00
Med Coverage Start Date:
Sex: M Marital Status: S
Phone Number: 1 [redacted]
Date Of Birth: [redacted]
Date Of Death:
Date Of Init: 1/01/2008
Date Of Re-hire:
Date Of Term: 6/01/2015

F3 End F6 Dues Inquiry F8 Hiring Hist

(PLEASE PRINT OR TYPE) #0509 HIPS

Your Last Name	First Name	Middle Name	Sex	Date of Birth Mo. Day Year
Menna	Leonard	J	☒ M ☐ F	[redacted]

Address [redacted] Zip Code [redacted]

Social Security # [redacted] Home Telephone [redacted]

Name of Employer	Date Employed
Liberty Ashes	11/8/07

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe)	Relationship
Carol Menna	Mother

Are you covered by any other Health Insurance? ☐ Yes No ☒ Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☒

List below all family members to be covered — Name (Indicate different last name if applicable)			Birth Date MO DAY YR	Relationship
		SS#	/ /	☐ Husband ☐ Wife
SPOUSE'S NAME	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter

ENTERED

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HIP

S — 01/08

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This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation signed by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

"Contributions of gifts to L I F E are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses."

Signature [signature] Date 12/21/07

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

Employee File Inquiry

Employee Name Data
PERSAD, RAMDEO

Employee Address Data
[redacted]

[redacted]

Beneficiary
HARRI, BUDHIA [redacted]

Shop: 0502 Soc Sec #: [redacted]
Dues Class: DUES Rate: $30.00
Med Plan: Rate: $.00
Med Coverage Start Date:
Sex: M Marital Status:
Phone Number: 1 [redacted]
Date Of Birth: [redacted]
Date Of Death:
Date Of Init: 10/01/2004
Date Of Re-hire: 6/01/2007
Date Of Term: 6/01/2014

F3 End F6 Dues Inquiry F8 Hiring Hist

L I F E

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Signature [signature] Date 7/9/07

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL

(OVER)

(PLEASE PRINT OR TYPE) #0506 Helper

Your Last Name	First Name	Middle Name	Sex	Date of Birth Mo.	Day	Year
PERSAD	RAMDEO		☐ M ☐ F			

Address	City	State	Zip Code

Social Security	Home Telephone #
[redacted]	( )

Name of Employer	Date Employed

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe)	Relationship
Change / OUT NO NAME	

Are you covered by any other Health Insurance? ☐ Yes No ☐ Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☐

List below all family members to be covered

Name — indicate different last name if applicable			Birth Date MO DAY YR	Relationship
		SS#	/ /	☐ Husband ☐ Wife
SPOUSE'S NAME	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter

ENTERED

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(PLEASE PRINT OR TYPE) #0808 Multi Plan

Your Last Name	First Name	Middle Name	Sex	Date of Birth Mo. Day Year
PERSAD	Ramdeo		☑ M ☐ F	[redacted]

Add[redacted] St[redacted]

Soc[redacted] Home Telephone ( ) [redacted]

Name of Employer Liberty ASL INC | Date Employed

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe) | Relationship

Are you covered by any other Health Insurance? ☐ Yes ☑ No ☐ Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☐

List below all family members to be covered

Name *Indicate different last name if applicable*			Birth Date MO DAY YR	Relationship
		SS#	/ /	☐ Husband ☐ Wife
~~SPOUSE'S NAME~~ Change name	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different) ~~Persad Ramdeo~~	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	[redacted]	FIRST	[redacted]	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	☐ Son ☐ Daughter

ENTERED

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LBP – 0506
LQ – 0502

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"Contributions of gifts to L I F E are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses."

Signature ....[signature]........ Date 4/5/07

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)